World Vision Relief & Development Inc.

MIDTERM EVALUATION
WORLD VISION
CHILD SURVIVAL PROJECT
BARAHONA PROVINCE
DOMINICAN REPUBLIC

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Submitted to:

Child Survival and Health Division
Office of Private and Voluntary Cooperation
Bureau for Food and Humanitarian Assistance
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LIST OF ACRONYMS

ARI	Acute Respiratory Infection
CSP	Child Survival Project
DIP	Detailed Implementation Plan
DR	Dominican Republic
EPI	Expanded Program of Immunizationa
KAP	Knowledge, Attitudes and Practices
MOH	Ministry of Health
NGO	Nongovernment Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
TT	Tetanus Toxoid
USAID	United States Agency for International Developnent
WV	World Vision
WVI	World Vision International
WVRD	World Vision Relief & Development, Inc.

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I would like to especially acknowledge the members of the team who carried out this evaluation. Each member brought an enthusiasm and interest that contriiuted to the overall product. The following members also contriiuted written materials that were incorporated into the final product:

Carmen Graveley	Dr. Milton Amayun
Santiago Rodriguez	Dr. Josefina Chavez
Ana Cristina Gellert	Nertha Castro

In addition, I would like to thank all the World Vision Dominican Republic staff for the logistical, program, and moral support they provided throughout the evaluation.

EXECUTIVE SUMMARY

The midterm evaluation for the World Vision Child Survival Project (CSP) in the Dominican Republic was carried out by a team that included the project manager, an intern from World Vision, the headquarters health director, a representative from the PVO national organization, a representative from the Ministry of Health, a representative from the Pan-American Health Organization, and the World Vision Dominican Republic director of operations. Field staff participated actively during the time spent in Barahona. The evaluation took place from September 16, 1993–September 24, 1993. Six days were spent in Barahona interviewing field staff, meeting with the Ministry of Health, and visiting communities. The methodology was qualitative and participatory, using structured interviews both in groups and individually at different informationcollection points. The report was written by Marcie Rubardt, consultant. The total cost was approximately $6,000.

The main accomplishments of the project are 45 well trained health promoters who are providing Child Survival health promotion to 100 percent of households in their assigned areas. At the household level, the project has attained complete actual immunization coverage of 80 percent of children under two, 66 percent of mothers treating diarrhea with oral rehydration, and 26 percent of women exclusively breast-feeding their infants up to four months of age. All households in the 15 intervention villages are registered in the information system, and 100 percent of target children for each intervention have been identified and are being followed.

The strength and unique characteristic of this project is its integration with expanded development activities being implemented by the sponsorship sector of World Vision. The project staff work together as a team to support health committees and identify and meet community needs. A key example is the provision of supplemental food by the development staff to those children identified as undernourished by the health promoters from the Child Survival project. This project has learned a lot about how to integrate work without integrating budgets or lines of accountability and can provide a model for other projects.

This project is going very well and there were only a few significant recommendations. These included simplification of the information system, additional effort to get clinic level MOH staff involved, and more careful planning of the phasing down/out process. While health promoter retention and motivation continue to be a problem, the use of a revolving credit fund as a motivator may provide a creative solution. All recommendations were developed and reviewed at the field level and have been reviewed with field office management staff as well as the staff of WVRD. The project staff intends to have this report translated and will review it with health committees, MOH personnel, and CONASUMI.

The Child Survival Project is located in the provinces of Barahona and Barohuco in the southwest region of the Dominican Republic. The primary focus of the project has been in the Barahona Region, working in 15 peri-urban communities with a total population of 10,220 located in two groupings: one along the coast west of the town of Barahona and one along the river to the north (see map in appendix). The health staff also provides training and support in health to World Vision development facilitators who are also working in

25 communities in the province of Bahoruco and a marginal slum in the capital. The town of Barahona is located about three hours' drive to the southwest from the capital.

The purpose of the evaluation was to review the recently completed midterm survey and to consider the appropriateness of expansion more extensively into the Bahoruco Province, as well as to evaluate the project's progress towards its objectives for the current work in the 15 Barahona villages. Project staff participated throughout the evaluation, which provided opportunity for self-evaluation and reflection regarding the project.

I. METHODOLOGY

The evaluation took place in the Dominican Republic from September 16-24, 1993 (see schedule in appendix). The first two days were spent in Santo Domingo meeting with management staff from World Vision and the Pan-American Health Organization and preparing the strategy for the remainder of the evaluation. The team then traveled to the town of Barahona, which became the focal site for the remainder of the evaluation. Of the five days spent in Barahona, two were spent meeting with field staff and the Ministry of Health; two were spent visiting villages in both Barahona and Bahoruco; and the last day was spent discussing and reviewing the results. The remaining two days were spent presenting the information locally and at USAID and working on the final report.

The evaluation team included:

Marcie Rubardt, RN, MPH-Consultant, Team Leader
Carmen Gravely, BS/Nutrition-Project Manager
Ana Christina Gellert, MPH-Intern, World Vision
Santiago Rodriguez, BS-Director of Operations, World Vision
Dr. Milton Amayun, MPH-Director of International Programs, World Vision
Dr. Josefina Chavez-Health Director, Food For the Hungry
Dr. Victor Ventura, MSC-Epidemiologist, Regional Ministry of Health
Dr. Leo Nelth-Pan-American Health Organization

Of these people, only the first three were able to participate throughout the full time of the evaluation. Others participated from one to five of the days. In addition, the three Child Survival field staff, as well as several of the World Vision development staff, participated actively during the time the team was in Barahona. The participation of the Food For the Hungry representative and the headquarters representative allowed for a useful exchange of ideas across projects as well.

The first part of the evaluation process involved the completion of a Knowledge, Attitudes and Practices (RAP) survey in August. This was carried out by the health team with the help of a representative from headquarters. Clusters selected in each of the 15 intervention villages gave a total sample of 208 households.

The methodology chosen for this part of the evaluation was qualitative and process oriented in nature. Evaluation discussions were informal but guided-not usually following specific questions but rather more general content areas. The team leader guided these discussions to assure that all content areas needed for a given interview or group discussion were covered, but all members of the evaluation team freely added comments and additional questions. Many members of the World Vision staff participated in different parts of the evaluation (see appendix for a copy of the topic areas and specific questions for each interview or group).

While the whole team was involved in most of the information gathering, different team members were assigned sections of the evaluation guidelines for which they were to take responsibility for writing. Their input has been included in this report.

Information was collected at a variety of different points. It was collected through individual interviews, focus groups, and home visits. The format for these interactions varied from structured questions to guided discussion based on interview goals (see appendix for specific interview questions and goals). These multiple perspectives provided the opportunity to verify the information collected from different perspectives.

Specific information points included:

1. Home visits to mothers with children under two years old.

2. Meetings with members from local village development committee.

3. Meetings with local clinic health staff.

4. Meetings with village health promoters-both individually and as a group.

5. Meetings with both the health and the development teams from World Vision.

6. Meetings with the Regional Public Health Director from the Ministry of Health.

7. Meetings with World Vision management team.

II. PROJECT DESCRIPTION

The World Vision Child Survival Project is implementing five interventions. These are as follows:

A. Immunization

The project trains health promoters and mothers in the importance of immunization and the monitoring of immunization coverage. Health promoters register all children aged O-24 months, provide assistance to the Ministry of Health (MOH) staff with motivation and registration during immunization campaigns, promote immunizations at the household level, and obtain and administer vaccinations in cases where there is poor compliance, MOH campaigns are delayed, and/or fixed posts are far away.

B. Diarrhea1 Disease Control

The project trains village health promoters and mothers in the recognition of dehydration symptoms, appropriate rehydration and diarrhea1 treatments, and appropriate dietary management of diarrhea. The team also works with the World Vision development team on the installation and use of latrines and the development of potable water systems.

C. **Nutrition and Lactation**

The project trains village health promoters and mothers in the importance of early and exclusive breast-feeding during the first four months of life, appropriate weaning practices, frequency of feeding, and use of high protein/calorie foods for nutritional recuperation. Health promoters monitor weights of children less than 36 months old (the frequency of weighing depends on risk). The health team works with the development team to provide supplementary food and intensive education to children identified as moderately or severely malnourished.

D. Acute Respiratory Infections

The project trains health promoters and mothers in the recognition of two symptoms that indicate the need for acute medical care in children with respiratory infections.

E. Family Planning

The project trains health promoters and mothers in the importance of adequate spacing between children and the availability of specific options to control pregnancy. The health promoters make referrals to the health clinic for family planning and are also trained in the distribution of condoms and birth control pills. Condoms and birth control pills supplied by Profamilia are available most of the time through local village medicine chests directed by the health committees. The health promotor also maintains a limited supply for "emergencies" among her supplies.

The objectives for the Child Survival Project are:

	Yr 1	**Yr 2**	**Yr 3**	**End**
EPI: Complete immunization coverage in children 12-23 months before their first birthday	**75%**	**60%**	**85%**	**85%**
TT coverage of pregnant women before delivery	**40%**	**55%**	**70%**	**70%**
ORT: Reduction of infant mortality due to diarrhea dehydration.	10%	**40%**	**60%**	**60%**
70 percent of mothers know how to properly prepare ORS and use it when their children have diarrhea.	**30%**	**50%**	**70%**	**70%**
At least 85 percent of mothers continue to breast-feed their children when they have diarrhea.	**70%**	**80%**	**85%**	**85%**

ARI: 95 percent of mothers of children O-4 years know two or three signs of pneumonia and know where to take their children for treatment.	85%	90%	95%	95%
Nutrition: Reduce malnutrition (>2SD) by 50 percent among children under five years old.	20%	30%	50%	50%
Mothers exclusively breast-feeding for four months.	30%	50%	80%	80%

A register is maintained by the health promoter at the village level of all children under 36 months and all women aged 15-39. She uses this register to record her activities, to identify people missing interventions, and to prioritize her visits.

Each community has a development committee organized by the World Vision development project prior to the initiation of the Child Survival project. A health sub-committee is made up of the health promoters, along with one to two members of the development committee. The health coordinators, along with the development committee, facilitate the other sector of World Vision's work with the health promoters to encourage these committees to review information, monitor and support the health work, and function increasingly independently.

III. SURVEY RESULTS

While a more complete report of the KAP survey will be forthcoming, it is important to note some of the significant achievements and findings in the context of this evaluation.

- Forty-four percent of children aged 12-23 months had immunization cards and were completely immunized. This is contrasted to 19.5 percent in the baseline. The information system shows a complete coverage rate of 80 percent, as contrasted to 41 percent completely immunized based on history only in the baseline, but this does not take the maintenance of the immunization card by the mother into account. The coverage rate documented in the information system is above the year two objective.

- Twenty-four percent of women interviewed had immunization cards and had received two doses of tetanus toxoid. This is contrasted to zero in the baseline. The information system shows 49 percent of all women of childbearing age and 100 percent of pregnant women having completed two doses of tetanus toxoid. The coverage rate documented in the information system is well above the year three objective.

- Sixty-six percent of mothers of children experiencing diarrhea during the previous two weeks had treated it with some kind of oral rehydration. This is contrasted to 51 percent in the baseline and is above the year two objective.

- Eighty percent of mothers who were breast-feeding children experiencing diarrhea during the previous two weeks continued to breast-feed during the diarrhea episode. There is not a comparable statistic in the baseline, but this is above the year two objective.

- Seventeen percent of mothers were able to mention that "tired" respirations and retracted chest with respiration indicated the need for acute medical treatment. This is contrasted to 65 percent in the baseline and falls far short of the year two objective. The midterm survey required that these two specific symptoms be listed in order for the answer to be counted positively. The baseline was designed with a variety of alarm symptoms to choose from, of which any two allowed the answer to be counted positively, so the numbers are not really comparable.

- Twenty-six percent of mothers currently breast-feeding children under four months of age were not giving anything else. This is contrasted the statistic collected in the baseline indicating that 12 percent of women who had breast-fed had done so exclusively for four months. While not directly comparable, this indicates good progress, even though it is short of the year two objective.

- Based on the information system, 91 children out of an estimated 870 less than 36 months old (10 percent) have suffered from moderate or severe malnutrition. Of these, 34 are now in the normal range. Malnutrition has been reduced by 63 percent, which is well above the year three objective.

- Forty-nine percent of women not wanting more children in the next two years, or 33.6 percent of total women surveyed, were not using a modern family planning method. There is no comparable number in the baseline. This proportion falls considerably short of the year two objective.

- The rate of women currently pregnant was 7.7 percent.

- Twenty-nine percent of mothers of children with diarrhea in the last two weeks treated it with antibiotics or anti-diarrhetics. This is contrasted to 60 percent in the baseline.

- Twenty-three percent of mothers surveyed were self-declared illiterate.

- Eight percent of mothers surveyed indicated they had some form of income generation. The national average of households headed by women is 40 percent, and there is no reason to believe that the rate in the communities is much less than that.

- The diarrhea rate for cases in the last two weeks was 28 percent. This is comparable to the baseline. However, the survey took place immediately after Hurricane Cindy, which likely led to a higher than expected case rate.

III. RESPONSES TO SPECIFIC MIDTERM EVALUATION GUIDELINES

A. Accomplishments

The Child Survival Project of Barahona has been operating for 23 months. Of the total population of 10,220, the project has actually reached 2,044 families, 2,247 women of childbearing age, and 2,188 children under five. Of these, 286 are aged 0-11 months and 296 are aged 12-23 months. This is 100 percent of the total potential beneficiary population.

The project has in place a staff that includes a project manager for health, an area Child Survival manager, two area health coordinators who train and supervise volunteer village health promoters, a secretary, and an accountant. The health coordinators are nurses with a background in maternal child health, and the project manager is a nutritionist who was previously head of the nutrition department in the Ministry of Health.

The project has placed a lot of emphasis on training (see training summary in appendix). The Child Survival Team received 623 hours of training in 28 different sessions. Of these, 204 hours were specifically related to Child Survival interventions and 418 related to more general project goals and management. Health promoters received 104 hours in seven sessions on the five specific Child Survival interventions. In addition, they received five sessions for a total of 56 hours on more general project goals and management. There have been 35 community health education presentations for a total of 135 hours, 15 meetings held with the health promoters as a group, and eight meetings held to coordinate with other institutions working in the area.

Although the Child Survival Project has not officially initiated activities in the neighboring province of Bahoruco, the health staff has been providing training to World Vision development facilitators as well as to development committees and communities in this area. The health team has provided 64 hours of training in basic Child Survival interventions to communities in Barohuco Province. In addition, they have provided two days of training for the marginal communities in the capital in which World Vision is also working.

Health promoters have made 3,001 home visits-many times also accompanied by the health coordinators. Twenty-eight vaccination days were carried out by the health promoters. Of these, two were participating in national vaccination campaigns.

In coordination with the development sector of World Vision, the health project has also been involved with the administration of supplementary food to 24 children, the construction of 707 latrines with instruction regarding their use, the improvement of 14 water sources, and five clean-up days.

According to the monthly reports, the following numbers of community people have received specific training through community presentations in the Child Survival interventions (these are not unduplicated numbers):

Immunizations: 1,250
Oral Rehydration: 1,465
Acute Respiratory Infections: 1,402
Nutrition: 1,432
Family Planning: 1,030
Breast-feeding: 950

Fifteen mothers' clubs were organized. Of these, seven are meeting regularly and carrying out educational and income-generating activities.

Refer to the section on survey results for outcome information.

B. Relevance to Child Survival Problems

When asked during the midterm survey, mothers responded that the most common cause of child morbidity was acute respiratory infections (63 percent), fever and seizures (57 percent), diarrhea and vomiting (8 percent), and rheumatism (1 percent). At the time of the survey, 28 percent of children had diarrhea and 57 percent had respiratory infections within the past two weeks. Of those who had respiratory infections, 67 percent had experienced symptoms indicating they needed medical attention.

Respiratory infections and diarrhea are generally recognized in villages as the primary cause of child illness. These are directly addressed by the Child Survival Project. The balance of effort and resources appears to be appropriate, particularly if one considers that growth monitoring often provides an avenue for addressing other health problems. Given the low reported prevalence of malaria, further investigation into the reported incidence of fever and seizures may be warranted.

The midterm survey found a high prevalence of grandmothers taking care of children under five during their mothers' absence. In addition, they seem to have a significant influence over caretaking practices of children in general. The project should consider focusing some of their educational efforts in Child Survival education to these women as well.

The survey found a pregnancy rate of 7.7 percent, which is almost twice the national average. It also found that 25 percent of the mothers are under the age of 20. An article came out this month in a national medical journal reporting that 55 percent of births in the San Jose de Ocoa Hospital in a neighboring province were to women under 18 years old. Given the high fertility rate and the national problem of teen pregnancy, and given the progress the project has made in the child oriented interventions, the project should now shift more of its effort toward family planning and developing interventions to prevent teen pregnancy. The initiation of two

adolescent groups oriented both toward the Child Survival interventions and pregnancy prevention is a good start. In addition, the project should consider developing a special project for teen pregnancy prevention. Funds and expertise may be available nationally through the "Girl Child" program.

With regard to the family planning program in general, it was recommended that men need to be involved and included in the education and decision making around birth control. The development facilitators with World Vision, most of whom are men, provide a good resource for working with men in this process.

C. Effectiveness

In spite of the objectives having been set very high relative to baseline data, the project has done extremely well at meeting its year two objectives (see detail under survey results).

If one uses data from the information system to estimate vaccination coverage, the project has nearly reached its year three objective. However, when limited to vaccination card data, the rate is much worse.

The loss of vaccination cards seems to be a universal problem. The Ministry of Health is currently considering pushing for a policy that would require a vaccination card for school entrance. Other ideas suggested by the team to encourage its maintenance were as follows:

1. Coordinate with local health services so that anyone with a vaccination card would have first priority for service.

2. Discuss the problem with the mothers' clubs.

3. Regularly review with mothers the importance of the information on the card.

4. Consider selling cards either initially or when replacement is necessary. As it is against national policy to sell the blue Ministry of Health cards, the project could implement the use of the pink growth monitoring cards, which are allowed to be sold. These also have vaccination information on them. This would have the added advantage that mothers would also have the information on their children's growth status with them.

Health promoters have been bringing vaccines into their communities and administering them to children when there has been a problem with the mother not bringing her child to the clinic. This has helped increase coverage, particularly when national campaigns are not getting vaccine out to the villages with sufficient regularity. Given that these health promoters usually have some recognition from the Ministry of Health and that they, at least theoretically, have a supervisor in the local clinic, this may actually be a sustainable intervention. However, this issue should be considered further.

While the progress toward dehydration prevention and control has been good, one of the health promoters had an educational idea the team thought was worthwhile to promote. She suggested making a small poster with the basic instructions for mixing ORS that could be left on the wall of every house receiving ORS training. The poster would provide information for the mother to refer to in case she forgets and would also provide a way to extend the information to other people who may visit her.

With regard to breast-feeding, while the project seems to have doubled the rate of exclusive breast-feeding, it is still below the year two objective. Although breast-feeding and early breast-feeding rates are very high, the problem seems to be one of exclusivity. The need to feed babies water, herbal tea, and juice at early ages is firmly entrenched in traditional beliefs. As grandmothers do a lot of the caretaking, this influence is passed on. The problem is twofold: the administration of the liquids themselves, which may not have been boiled; and the pervasive use of bottles to administer them, which are often not as clean as they need to be. The team recommended that the message "never use a bottle" be added to the basic breast-feeding message of "breast milk only until four months." The recommendation that the team direct educational efforts toward grandmothers may also help alleviate this problem.

Targeted risk groups as defined in the first annual report are being effectively identified and reached through the registration system. These include all newborns, children O-4 months not being breast-fed, children 0-11 months not fully immunized, malnourished children with repeated bouts of diarrhea, children under five not administered ORT when they have diarrhea, and children O-36 months who do not gain weight for two consecutive weighings. Pregnant women who have not received at least two prenatal checkups with at least two doses of TT are also targeted.

The midterm survey showed a much lower rate of symptom recognition than either the baseline or the objective for acute respiratory infections. This is because the definition of a correct answer was much more narrow, allowing only for two specific symptoms (tired breathing and retracted chest) instead of any two symptoms to count. There may also be a lack of correspondence to the message being taught in households. The project may want to verify through feedback whether understanding of its ARI message leads to correct answers on the survey. From a qualitative point of view, mothers and health promoters with whom the team had an opportunity to talk all mentioned difficulty breathing and retracted chests but did not mention tiredness.

While there is no comparable number in the baseline survey, it appears that contraceptive use in the midterm survey is less than it was at the start. The team does not have an explanation for this but guesses that it is probably methodological. The subjective impression of all concerned is that use rates have improved. The current rate of 33.6 percent of all women surveyed, or 49 percent of those who don't want children, is well short of the desired 80 percent. However, given that only 74.6 percent of women surveyed did not want another child within the next two years,

the objective of 80 percent of couples using contraceptives is unrealistic. As mentioned previously, the evaluation team strongly recommended that more emphasis be placed on this intervention, particularly in young women.

D. Relevance to Development

Community barriers to meeting the needs of children include:

1. **A** lack of knowledge of some basic child caretaking practices;

2. Lack of adequate income;

3. Health and education services that are often unreliable and inadequate (for example, inadequate medicines in clinics or inadequate school maintenance or space);

4. Lack of healthy living environment (for example, latrines, clean water, garbage control);

5. Illiteracy, particularly among the women;

6. Annual migration for the coffee harvest, making continuity of education and health care difficult;

7. High number of female-headed households.

The ability of the Child Survival Project to truly integrate itself with the development activities of other sectors in World Vision is impressive. The development sector of World Vision is working in the same communities as the Child Survival Project. Three facilitators are assigned to cover these communities. Prior to the initiation of the Child Survival Project, these facilitators had organized development committees and had begun development projects. With the beginning of the project, the health coordinators began to work with these facilitators to form health sub-committees, to select health promoters, and to continue supporting the work of the development committees.

Specific development projects that are contributing to families' ability to keep their children healthy include the following:

1. Primary education support programs, including school-building rehabilitation and establishment of low-cost bookstores.

2. Construction of latrines.

3. Construction and maintenance of aqueducts for drinking water and/or irrigation.

4. Garbage disposal programs.

5. Training women in sewing and handicrafts.

6. Establishment of local drug chests with basic medicines sold at cost (these are now supported by the health team).

The team considers the development committees to be strong in nine of the 15 communities, and in three others they are doing moderately well. Only three of the communities have minimally functioning committees that need a lot of support. In the stronger communities the committees are independently running the drug chest, monitoring the work of the health promoters, and providing money for incidental expenses related to the health project such as transportation money for the collection of vaccine.

Tension was initially reported between the development team and the new Child Survival team. The Child Survival team was seen as a separate project, and sharing of resources was difficult. The staff seems to have worked through a lot of the misunderstanding and it is clear that there is a lot of cross involvement in the work. The tezm strongly recommends that all the staff of World Vision continue to work toward the full integration of the two projects. Specifically, as the health team begins to work toward a second phase of expansion into Bahoruco, more cross support and cross supervision between projects at the village level may be more efficient. More coordination of village visits between the health coordinator and development facilitator may also help.

E. Design and Implementation

Design

The Child Survival Project has limited its primary focus to 15 target villages with a total population of 10,220. The project has included additional activities in training for World Vision, areas not currently included in Child Survival. These additional activities do not seem to have negatively affected the work in the primary villages and have served to increase awareness regarding health needs and Child Survival interventions in areas to which the health team hopes to eventually expand Child Survival interventions.

The project began with an emphasis on immunization, growth monitoring and breast-feeding, and oral rehydration. It later expanded to include acute respiratory infections and family planning.

The possibility of extending the project to additional villages in Bahoruco Province was mentioned in the DIP. At the time the DIP was written, the number of villages in Bahoruco in which the development sector was working was 16. That number has now expanded to include 25 villages. The evaluation strongly recommended that the project not undertake this expansion at this time. There were several reasons:

1. There is not enough money left in the budget to hire the additional staff necessary to support such expansion.

2. One year is too short to establish a new program in villages if continued funding is not assured.

3. Some of the interventions and design issues mentioned in this report need to be resolved in the existing project villages before expansion happens. For example: simplifying the information system, motivating health promoters, and strengthening pregnancy prevention.

The objectives proposed in the DIP are measurable and mostly reasonable. However, the proposed reduction in diarrhea mortality will be difficult to measure since there was no baseline. Baseline data could probably be attained through a review of hospital records since the majority of deaths in the project area occur in hospitals. However, this would require extensive time and is probably not worth it. As mentioned previously, the other problematic objective is the level of couples using modem contraceptive methods, since the objective is higher than the total proportion of couples who do not want to have children in the next two years.

While management is open and willing to make changes where necessary to meet objectives, few have been necessary. One area where changes were made was in the information system. The original plan was to use the Ministry of Health information system. However, there is an organization of NGOs which developed and tested an information system that the team felt would better provide the information needed to evaluate the project interventions and to adjust activities as needed and that the health promoters at the village level could manage. They are very open and ready to implement any additional changes or refinements that may be offered with the help of technical assistance.

Management and Use of Data

The project is collecting useful data. All levels of the project, from the manager down to some of the health promoters in the villages, understand the advantage of and are using the information collected to identify needs, recognize progress, prioritize and plan the work to be done, and identify gaps in coverage. However, the current system is quite complicated and requires an extensive amount of effort to maintain. There is concern whether the benefits are worth the effort of the system as it is currently functioning.

The information system at the village level depends on notebooks where all children under five and all women of childbearing age are registered. Next to the names are a series of pages where results of various Child Survival activities can be recorded. There are some promoters who have organized their notebook efficiently and are keeping it up regularly. For these, the system seems to be working well. They do not find it burdensome and feel it helps their work. However, for many the effort required to get their notebooks organized and caught up, and the discipline to keep

them up on a regular basis so that the work doesn't pile up, has been a significant barrier to the functioning of the system as a whole.

An additional source of information that had been proposed in the DIP was the development of mother sentinels to monitor the incidence of immunizable diseases in the communities. This may not be necessary given the level of penetration of the health promoters. However, these mothers may be able to provide some additional support to the health promoters and at the same time provide a monitoring function for the efficacy of the vaccine being administered. During the evaluation team's visit to the local clinic, it appeared that the refrigerator temperature may have been too warm and therefore the cold chain may have been broken. The health team should evaluate whether adding these sentinels would be a useful component, or if they would require more work than they are worth given the success of the health promoters.

Local management staff have both the commitment and the capacity to maintain the information system. All of the health promoters are fully literate and should be able to maintain their notebooks, particularly if the system were somewhat simplified. However, the staff does not have the capacity to review and analyze the system to make the necessary improvements. The evaluation team is strongly recommending that the project seek technical assistance in the review and revision of the system.

The information system is currently focused on, maintained by, and primarily serving the health program. It would be extremely useful for the technical assistance person to look at the information needs of the agency as a whole. A system that would be applicable to and maintained and supported by all sectors would increase the efficiency and the use of the information generated. It is also recommended that a current member of the staff be appointed immediately to be responsible for the maintenance of the information system.

The project completed both a baseline and midterm KAP survey. All of the project staff is well aware of the results of both surveys, and the information is considered in project discussions, planning, and feedback to villages. The baseline survey reinforced the need to emphasize diarrhea and dehydration control as well as to focus on acute respiratory infections. It also showed that both knowledge and practices in most areas of Child Survival were very low. The midterm survey has shown that the project has made significant progress in most intervention areas. This has provided considerable reinforcement for the paid staff. There are plans in the next couple of weeks for meetings with the health promoters, and eventually with development committees, to review the results. The hope is that this will help provide motivation and support for the work happening at the village level. Information provided by the midterm survey combined with other information collected during the evaluation will hopefully lead to an increase in project focus on family planning and pregnancy prevention.

Data from the registration and information system is used regularly by the coordinator and supervisors for supervision, planning, and monitoring. The monthly

reports from the health promoters help them prioritize their efforts based on progress and promoter participation in specific villages. As mentioned previously, the extent to which the information is maintained and used at the village level varies considerably and also provides considerable frustration to the coordinators. When it is working well, the information from the promoter's notebook is used at the village level to help them prioritize the households needing most attention and follow-up. Specifically, it may help determine which families need supplemental food through the development program and which families need extra effort or even specially brought vaccine to get their children immunized.

As a balance to the quantitative information from the surveys and information system, the project supervisors use their personal knowledge of the impact areas, observations, community opinion and reporting, their work with the development committees, exchanged ideas with the development facilitators, and discussion of specific cases to verify the quantified data and to provide more depth of understanding to the numbers.

Information from the information system, including monthly reports, is shared regularly with development project staff and regional Ministry of Health personnel. Health supervisors also make an effort to feed back information to the health promoters regarding their progress. A plan to maintain village mural boards providing health information feedback at the village level was a strength of the DIP. Unfortunately, while this was started in many of the villages, it has not been successfully maintained. There may be a need for more committee and household training regarding the relevance of this information before it will be seen as something important enough to maintain. Information from individual villages regarding activities, target populations, and coverage has not routinely been shared with Ministry of Health personnel at the local clinic level. This information has the potential to considerably help the Ministry of Health with its immunization program, as well the possibility of increasing their orientation to using population information in the planning and evaluation of immunization programs.

One of the purposes for the participation of the health director from the headquarters was to share lessons learned across projects. On a more local level, the World Vision development staff are actively absorbing many of the Child Survival lessons learned and incorporating them into the agency's other projects.

Community Education and Social Promotion

The primary activity of the project is community-based education and health promotion. At the village level the health promoters have one primary message they use for each intervention, with secondary explanation and theme development. They also have picture notebooks on diarrhea and breast-feeding which they use to help explain these messages. It was clear in the villages visited that these picture notebooks were well used. No printed materials are distributed. Through the mothers' clubs social drama, games, and individual case studies have been used as

learning tools. These have also been modeled in the training of health promoters and Child Survival staff.

Many of the materials and messages used by the project were developed in a collaborative effort with 14 other PVOs through the University Research Corporation. Initial materials were developed and then tested in community focus groups. The project health coordinator and supervisors participated in this testing process.

Consistency of message at the village level is assured in several ways. Primarily, the health coordinators do joint home visits with the health promoters as part of their regular supervision. They also review specific cases and get feedback through the mothers' clubs regarding the messages being received. Effectiveness is primarily evaluated through subjective impressions, individual stories, and the midterm survey results.

Acute care, medicines, contraceptives, and even food given by the World Vision supplemental feeding program are all relatively accessible. As a result, community people are in a position to follow up on recommendations made by the health promoters. Also, given the general availability of specific services, the project emphasis on working with committees and providing individual health education and motivation at the household level is appropriate.

Human Resources for Child Survival

The Child Survival team is composed of the project manager, the area health coordinator, two area health supervisors, a secretary and an accountant. This team trains and supports the work of 45 volunteer village health promoters. A coordinator of the health information system had been planned in the DIP. However, due to inflation and actual salary levels, the budget proved inadequate for both the accountant and the information system manager. This was unfortunate, as some of the current frustration with the information system may have been avoided had this person been available throughout project implementation.

Training for the volunteer health promoters has been extensive, as outlined in the outputs of section one, and in the appendix. The format for this training included role playing, case studies, and regular review. In addition, health promoters receive regular visits from their supervisors which are seen as an important opportunity for one-to-one reinforcement and training. Those promoters who were active and involved with the project had a strong knowledge base in the Child Survival interventions. However, the evaluation team found that several of the health promoters with whom it talked had gaps in their information. By report, these were newer promoters that had not had access to as much training as those that started with the project. Extra effort needs to be given to new promoters and to those promoters that are weak in specific content areas to assure the appropriateness of the information being taught at the household level. A rotating schedule for reviewing information would probably also be helpful.

Motivation and retention of health promoters has been a problem for this project. Fifty percent of promoters trained in the past two years have quit; there are currently only 35 active promoters, with the remaining ten being recruited. This poses a significant threat to the continuity of service in the communities, and the continuous retraining is a drain on project resources. In addition, both the MOH and another NGO in the area have paid health promoters for their services. While everyone now realizes that this is difficult to sustain, the expectation has been planted.

Each promoter is responsible for something between 36 and 52 families with the norm being in the mid-40s. Some of the more active health promoters indicated they are working six to eight hours per week to visit the number of families they feel need it. Motivators for these women included the personal satisfaction of helping out people in their communities, the satisfaction of seeing a change in the dehydration rates from diarrhea, and enjoying working with children. Several of the promoters also have some training in nursing, which they appreciate being able to use. Barriers and difficulties they mentioned included not having the time-particularly since several of them are also working-difficulty with the information system, and not being paid. This last was reported by project staff as health promoters were too embarrassed to bring it up directly. Pressure from husbands to quit and moving to the capital have also been causes for attrition.

To address the motivation problem the Child Survival Project began implementing a small-scale credit program specifically for the health promoters about three months ago. Thus far, about eight women have received loans and several successful enterprises have been started. These include selling clothes, making and selling household linens, and running a coffee stand next to the cock fighting ring. This program may have potential for alleviating some of the motivation problem as long as women don't leave their health work for their businesses. The promoters don't feel this will be a problem. However, the team recommended getting technical assistance from the development sector in the management of this credit program. World Vision already has significant skill in this area, and it will probably be helpful to separate the business side from the supervision of the health program.

Other suggestions to address the issue of motivation and attrition include:

1. Give more specific selection criteria to the community during the selection process. These might include age, experience, husband's support, and education level, for example.

2. Look for middle- to older-aged people who might be more stable and might have more time to devote to the work. Dr. Chavez mentioned that Food For the Hungry has not experienced nearly as high an attrition rate and that this might be the key difference.

3. Explore giving health promoters priority for any health services.

4. Reevaluate whether the project might be requesting too much of health promoters. If so, the coordinators need to work more closely with the project to prioritize work and limit the interventions to those most in need.

Supplies and *Materials* for *Local Staff*

Materials made available to health promoters at the village level were covered under section four on community education and social promotion.

Extensive materials have been made available to the coordinators of the health project through local organizations as well as the home office. In particular, a series of manuals for promoters, supervisors, and coordinators with content for different interventions was developed in collaboration with the PVO group Consejo Nacional de Superiviencial Materno-Infanitl (CONASUMI). Many of these were available both in Barahona and in Santo Domingo, and several were referred to during the course of the discussions. One of the limitations to the dissemination of such information is that none of the project staff speaks English.

Quality

All of the project staff clearly exhibit solid technical knowledge and skills in the Child Survival interventions being implemented. This was evidenced throughout the discussions and during the community visits. They were also appropriate in their counseling of mothers when the opportunity presented itself during the team visits. As mentioned previously, there is less consistency and reliability in the household counseling done by the health promoters.

Supervision and Monitoring

Supervision happens actively and conscientiously at all levels of this project. At the village level, the health supervisors from the office in Barahona visit the participating villages an average of two times per month. During these visits they work with health committee members and with the village health promoters.

They review information from the recent health reports with the committees and help plan and improve services. They review the promoters' notebooks with the registration and HIS information with the health promoters in each of the 15 villages. They do joint home visits to families where the promoter has found some kind of problem, and they work with the promoters to identify needs and intervention priorities based on the information collected. Promoters indicated they feel well supported by their supervisors.

Two areas in health promoter supervision are sources of frustration for the supervisors. These have been maintaining promoter motivation and pushing promoters to maintain the information system. Both of these have been discussed previously.

The health supervisors are supervised by the area health coordinator, who is in turn supervised by the project manager. While this linear authority is clear in the organizational chart, it is also clear the Child Survival paid staff function very much as a participatory team. The area coordinator provides a lot of field support and training to the local supervisors, often working with them on village training sessions and filling in when health promoters have quit.

The project manager visits the impact area two to three times per month for three days per visit, in addition to attending monthly meetings for information review and planning and actively participating in any special projects or tasks, such as the recent KAP survey. All the staff also has the benefit of collegial relationships with World Vision staff functioning in other sectors. This allows for an exchange of ideas and amplification of purpose that is useful to everyone.

Use of Central Funding

Since the beginning of the project, various headquarters staff members or Latin America regional office staff have visited the project to provide technical assistance and encouragement on various aspects of project management. These include:

- Milton Amayun, World Vision Relief and Development (WVRD) director for International Health Programs, visited during the first month of the project to provide guidance on project start-up.

- Sandra Jenkins, WVRD finance officer, provided individualized training for finance staff on financial management and grant compliance required by USAID-funded Child Survival Projects.

- Fe Garcia, WVRD senior program development officer for Health, visited twice and led two workshops: sustainability and information systems. These were attended by MOH staff and other NGOs working in the health sector in the Dominican Republic as well as by the Child Survival and development staff from World Vision.

- David Befus, World Vision International (WVI) regional director for technical services based in Costa Rica, led a seminar for project staff on practical guidance in the management of income-generating activities.

- Tom Ventimiglia, WVRD program development officer, trained project staff on how to conduct a survey and on data processing during the midterm survey.

In addition, WVRD headquarters provided the following technical support:

- Organized the consultancy of Dr. Jim Rice, an expert on sustainability from Minneapolis, who led a follow-up workshop on sustainability.

- Arranged the participation of the project manager and the project coordinator in the PVO CSSP workshop in Bolivia for Child Survival projects in Latin America.

- Prepared quarterly programmatic and financial summaries from monthly project reports. Copies of quarterly summaries were submitted to Washington and disseminated throughout the WVI Partnership.

- Represented the project and its needs during discussions with WVI's top management.

- Arranged the consultancy and travel of a midterm evaluation consultant.

One constraint the WVRD office faces is the lack of materials in Spanish and the lack of many headquarters staff who speak Spanish. This has led to some frustrating experiences where translation was a barrier to effectiveness.

At the beginning of the project, the World Vision Dominican Republic (WVDR) field office reported to the WV office in Guatemala, and not directly to the regional office. This was perceived by the field office staff as another layer of bureaucracy which complicated lines of accountability and delayed decision-making. During the last quarter of FY93, WVDR has been upgraded to the status of a program office, and the director will now report directly to the regional office in San Jose, Costa Rica.

WVRD is receiving $22,000 in central funding from A.I.D. for this project. WVRD matches this amount and combines the funds with those from other projects or other grants to achieve more for less. For example, WVRD staff visiting the CS project in Haiti often visit the DR project as well, saving time and airfare, while maximizing efforts of staff. A joint workshop on grant financial management and compliance was conducted with staff from projects in Haiti and the DR participating together. Headquarters support is a vital part of the DR Child Survival program and this would not be possible without central funding from the grant.

PVOs Use of Technical Support

It is apparent that the project has been quite resourceful in accessing and organizing technical assistance obtained internally within the organization, locally through MOH, and from various other nongovernmental institutions.

Within the organization, the technical assistance accessed through WVRD and WVI's Latin America regional office has been described above. In addition, within the field office itself, there are technical resources the project has accessed on a continuing basis. Examples include the program director, Dr. Cesar Lopez, Ph.D., an expert on sustainability in agriculture; the operations manager, Santiago Rodriguez, with almost ten years of experience in NGO project implementation; the finance director, Claudio Done, well trained in income-generation activities; the staff of community

development projects and that of the Escuela Campesina de Agricultura Sostenible (ECAS). In return, the CSP staff have provided technical assistance on health issues to the rest of the projects of WVDR. This exchange of technical expertise cemented the obvious good relationships between the CSP and the other community development projects of WVDR.

Locally, project staff have utilized many local resources for technical assistance, especially in training (see list of specific training in appendix). Most important have been the following organizations and institutions:

- University Research Corporation, USAID contractor for child survival, on different CS interventions and various aspects of CS program management.

- Ministry of Health, or SESPAS, on various CS interventions, most especially EPI.

- The Peace Corps on the use of health promoters in Primary Health Care programs.

- CEDOIS (Centro Dominicano de Organizaciones de Interes Social) on the rights of children.

- PLUS (Patronato por la Lucha contra el SIDA) on different aspects of AIDS programming.

- CENISMI (Centro Nacional de Investigaciones en Salud Materno-Infantil) on the design and implementation of the baseline survey.

- CONASUMI (Consejo Nacional de Supervivencia Materno-Infantil) on national Child Survival policies and strategies for PVOS.

- COSASO (Coordinadora en Salud del Sur-Oeste) on regional policies and strategies for Child Survival and development in southwestern Dominican Republic.

- Other PVOs like Food For the Hungry, Church World Service, and PLAN International that have professionals on staff who regularly share with WVDR staff various experiences on issues directly related to CS implementation.

It must be noted from the above list that there are many capable and available Dominican professionals from different institutions. The project has networked with these institutions effectively and the staff have applied what they learned to their project implementation.

In addition to the above technical assistance received, two members of the project staff participated in the PVO Child Survival workshop in Bolivia hosted by Johns

Hopkins and Proyecto Esperanza. Two members of the staff also attended a seminar on "educacion popular" hosted by WV Guatemala.

All of the above technical assistance was deemed positive and served to strengthen the project, although some themes were more directly related to project activities than others.

With regard to additional technical assistance needed, help with the health information system design has been repeatedly expressed as urgently needed by the project manager, the project coordinator, and other members of the staff. Technical assistance on this will be provided by a member of the staff from WVRD.

As mentioned previously, other aspects of the project potentially requiring outside technical assistance in the next 12 months are family planning, adolescent pregnancy prevention, and income-generation activities. Local consultants are recommended.

There are no perceived obstacles to acquiring consultants who will provide technical support and advice to the project.

Assessment of Counterpart Relationships

The principle counterpart organizations to the Child Survival Project are the World Vision Development Program and the Ministry of Health. With the World Vision development staff there has been extensive training exchanged across programs; some collaborative supervision of committees and promoters at the village level occurs; and joint planning and discussion takes place regularly. When the health project begins to decrease its inputs to the 15 Barahona villages, it is expected that the development facilitators will be able to provide some of the transitional supervision and support at the village level.

With the Ministry of Health, the maintenance of counterpart relationships requires considerably more effort. The program manager and area health coordinator both meet regularly with staff from the Regional Public Health Department. In addition, the regional epidemiologist participated in two days of the evaluation process. At the clinic level, the area supervisors have met with clinic staff and invite them regularly to community activities and local Child Survival training. Project staff have worked with clinic staff in carrying out two national immunization campaigns at fixed posts in the communities. Every clinic has a person assigned to supervising village health promoters during immunization efforts. It was hoped that these people would eventually be able to take on the supervision of the expanded number of community health promoters that the project has trained and to support them in the wider range of Child Survival activities. However, participation from clinic staff has been minimal in any of the community activities or training, and staff have felt frustrated by the lack of motivation.

For better or worse, the long-term sustainability of the project is going to depend on the extent to which the Ministry of Health, particularly at the clinic level, feels

participation and ownership in the project. Even if it continues to be frustrating, project staff need to make every effort to include clinic staff at every step.

1. Clinic staff need to get copies of monthly reports of all the Child Survival activities (not just immunization) from supervisors as well as those from the health promoters that pertain to the villages in their areas of responsibility. It would also be useful for project staff to review these reports with them on a regular basis. This would provide an avenue for training them in the use of population data to provide denominator information for the planning and evaluation of their immunization efforts.

2. Health supervisors need to consider the MOH health promoter supervisors as their direct counterparts. They need to look for every opportunity possble to orient them to the community activities in Child Survival, train them, and motivate them in any way possible--even though it is often frustrating.

3. In meetings during the evaluation, the Ministry of Health expressed an interest in seeing World Vision expand its health activities to some of the urban areas in the town of Barahona. While it is understood that the next area of expansion for the Child Survival project needs to be the 25 Barohuco communities where the development team already has activities established, it would be beneficial to consider this request when the development team decides on further extension of its efforts.

An additional frustration evidenced in both the baseline and midterm surveys has been the continued high rate of prescribing antibiotics and anti-diarrheal medicine by clinic doctors as treatment for diarrhea. This problem is recognized at the regional level and is one of common medical training and practice. While not something the project can address independently, it should continue to make efforts to encourage and influence the physician in-service training in this area.

All of these problems were discussed freely with the MOH epidemiologist who participated in the evaluation and have been the subject of ongoing dialogue with the Regional Director of Public Health.

Referral Relationships

There are four rural health clinics serving the 15 Barahona communities. They are all staffed with a doctor and nurse or nurse auxiliary, and the maximum distance anyone has to travel to reach a clinic is five kilometers. A serious attempt is made to keep these clinics supplied with basic medicines. There are also a couple of hospitals in Barahona, and transport is not usually a problem. While there is sometimes a problem with the activity level of the doctor and medicines may sometimes be scarce, it is fair to say that basic curative care is generally available.

The clinic visited during the evaluation was very well stocked with medicines, the doctor could be reached, and services were available. However, there were few

patients requesting services, and it appears that community people may not have a lot of confidence in the public health system.

An additional support to the curative system is the community drug chests that have been established through the village development committees. These are now supervised by the health team and are functioning in all of the 15 communities, While some of them are still having problems maintaining the rotating fund for medicine purchase, many of these are functioning in a sustainable manner. These were not set up with the expectation that the initial capital outlay be paid back but rather that it only needed to be maintained. It was suggested by Dr. Chavez from Food For the Hungry that they had successfully also gotten communities to pay back the initial capital and that this allowed them to establish drug chests in additional communities. The project may want to consider including this as part of the guidelines for setting up these chests in the new communities in Barohuco if they are able to expand the program.

PVO/NGO Networking

The 14 PVOs working in Child Survival in the Dominican Republic have formed an organization called Consejo Nacional de Supervivancia Matemo-Infantil (CONASUMI). World Vision has participated actively in this effort. This organization has provided a forum for sharing ideas, combining training efforts, jointly developing and testing educational messages materials, and coordinating programming and fund-raising efforts. This has been done with the support of the University Research Corporation which had a USAID grant for this purpose. Although the URC grant is finished, CONASUMI is continuing to meet and carry out these collaborative tasks. Dr. Chavez from Food For the Hungry was representing CONASUMI on the evaluation team.

Coordinacion de Salud del Suroeste (COSASU) is another organization in which World Vision is an active member. This organization attempts to address the regional-specific issues in the implementation of health programs. These include the coordination of activities between the different PVOs in the region and collaboration with the MOH (who is a member). At the moment this organization is weak, but there is an intention to revive it.

The information system currently in use as well as the five primary Child Survival messages and the visual aids and training manuals have all come out of the efforts and experience of CONASUMI.

Budget Management

The project is largely on schedule in its expenditures against the grant. There was a small underspending at the end of the first year, but project activities have accelerated during the second year. There is a projected total of $134,000 in expenditures at the end of the current fiscal year, leaving $68,000 of USAID funds

to be spent during the third year. The rate of spending per year over three years is as follows:

FY92 -	**$54,000**
FY93 -	$80,000 (projected maximum)
FY94 -	$68,000 (projection based on FY93 maximum)
Total	**$202,000**

It is almost certain that the project will spend the total available funds from the grant by the end of FY94, particularly because there is a plan to expand the income-generation activities as a motivation mechanism for the health promoters. There might even be a small deficit, but this can be covered by either WVRD funds or by the community development project funds.

During the third year it is recommended that the project restrain from a mode of geographic expansion and instead maintain its current level of activity in Bahoruco, reserving it as an area of proposed expansion for the project's second phase. There are areas of project implementation that need to be strengthened in Barahona, and these should be the focus of the remaining funds in the grant. Should there be any excess funds, these should be applied to the expansion of income-generating activities.

One remarkable thing noted by the project evaluation team was the amount of work project staff have done with a minimal budget. The project manager and her staff have creatively accessed resources, especially from the community development projects, to fill gaps in the CSP budget. Resources from the other WVDR projects have so far not been counted as part of WVRD's match to the grant, and it is suspected that if these were accounted for, they would be substantial, pushing higher the 52 percent match WVRD already applies to the project. The quantification of these additional resources would be useful in evaluating current programming as well as in the preparation of a proposal for a second phase.

A very tight system of budget controls is observed in financial transactions. Records are complete, well-organized and up-to-date, with a full-time accountant dedicated to the project carefully monitoring expenditures against budget. Financial supervision is rigorously provided by the field office finance division, the Latin America regional office and headquarters. Project financial reports are reviewed in detail by WVRD before quarterly financial reports are submitted to A.I.D. Washington.

The budget has had very few changes since the preparation of the DIP. These changes have been involuntary and were related more to differences in salaries or unfilled positions. The principal budget categories have been maintained close to the maximum levels projected.

F. Sustainability

Sustainability has been considered at multiple levels of this project. At the organizational level, the Child Survival Project has supported two workshops provided

by headquarters staff on sustainability. Staff from all sectors of WVDR as well as some people from other PVOs participated. An expanded definition of sustainability beyond that of just economic self-sufficiency and community organization mechanisms for achieving sustainability were discussed. During several of the evaluation discussions staff referred to concepts from that workshop, and it appears that many of the concepts have been integrated into their basic work orientation. It also provided the opportunity for staff in the development project to assimilate ideas around sustainability in Child Survival and apply them to work in other sectors.

At the community level, the most basic sustainability indicator is whether behaviors are changing at the household level. In this project, as documented by both the midterm survey and the subjective impressions of the health promoters, it does seem as though there is change-particularly in the administration of fluids and ORS for diarrheal episodes, in recognition of the importance of vaccinations, and in breast-feeding and weaning practices. The establishment of functioning mothers' clubs provides a forum for social reinforcement of these behaviors as well as some simple income-generation activities. As mentioned under the section on effectiveness, health promoters' bringing vaccine into homes or at least into community fixed sites is also a sustainability issue that needs to be considered.

Also at the community level, first the development project and now the health project have worked from the beginning in the establishment and support of development committees. In the case of the successful committees, these committees feel a lot of ownership of the work being accomplished, they provide a lot of support for the health promoters, and they intend to continue to do so whether World Vision continues to provide them a budget for their support. These committees have been trained in the significance of the health information system and have been involved in reviewing the monthly reports.

Lastly at the community level, the project is experimenting with the use of a revolving fund for income generation as a source of motivation for the health promoters. This was mentioned under the section on human resources. It appears that many of the health promoters recognize the problem of maintaining salaries on a long term basis and consider that the opportunity to borrow money for a small business may in reality be preferable. They complain that the $250 currently offered is inadequate, but the project's feeling is that small starts are more likely to assure high repayment rates, and there are several successful enterprises under way.

At the regional level, the relationships with the MOH and with the World Vision development projects are the basis for long-term sustainability. These have been discussed under the section on counterpart relationships.

The evaluation team came up with several recommendations that may contribute to long-term sustainability:

1. For both the health and the development projects, World Vision should look more closely at the matching effort and contribution required of the

community. There may be a tendency to "give" too much, thus increasing the community's dependency on outside resources.

2. The project needs to more actively plan for the time when there will be less intensive inputs into the 15 Barahona communities. A plan for phasing down needs to be developed in preparation for the expansion into the Barohuco villages, which is hoped for during the second phase.

3. The project ought to begin to calculate some of the real costs of its maintenance (for example, the cost per child completely vaccinated or the cost per envelope of ORS used). This would be useful information for the MOH and would provide a concrete idea of the cost of maintaining the current project.

G. Recurrent Costs and Cost-Recovery Mechanisms

There is a high level of recognition on the part of the staff of the issues related to sustainability. The financial, human, and material inputs required to maintain a project such as this are very much a part of this understanding. However, there is still a lot of experience and information needed before it is known what inputs are actually needed to achieve sustainability in the broader sense of the word.

The analysis of the second year of operations (when there were practically no expenditures toward capital investments) indicate that the project's estimated recurrent costs total $40,489 per year. This translates into a cost of $3.96 per beneficiary per year. This is relatively inexpensive given the array of services the project provides. However, there are many hidden costs that are not included in the calculation. The contributions of MOH's EPI vaccines and cold chain as well as the community development projects are not part of the figure given above.

It is assumed that the government will have difficulty taking over the responsibility of funding the project's activities. There are several reasons for this:

1. There is currently a lack of resources and commitment on the part of the government to assume the costs over the long term.

2. The principles of sustainability have not penetrated the MOH.

3. As mentioned in the last section, the true costs of Child Survival have not yet been calculated.

While the communities are open to eventually paying for the costs of health activities at their level and are already providing most of the costs of social mobilization through volunteers and community organizations, the recurrent costs per year would be difficult for the communities to assume at this time. What they have been doing over the past two years is to budget a certain percentage of the community

development project budget from WVDR to support health activities. This is a strategy that has tremendously reduced project costs.

Very little has been done to develop a system of fees for service to support the project. The one exception has been the establishment of community pharmacies that sell basic drugs at cost or just above cost. National policies dictate that some services (e.g., vaccinations) are provided free to the community.

In the framework of the current project, the supervisor support is not likely to be sustainable unless the EPI supervisors from the rural clinics can be motivated to assume it. The health promotion efforts in diarrhea control, nutrition and breast-feeding, immunizations, and family planning will be sustainable if the health promoters can be supported either by their committees, the development facilitators, or the MOH.

H. Recommendations

Recommendations have been made throughout the previous sections of this report. Following is a summary of these recommendations:

Interventions

- According to the needs identified in the surveys and by more subjective information, the project should prioritize teen pregnancy prevention, family planning efforts, and development of the income generation program for health promoter motivation during the coming year. It should seek out locally available technical assistance to do this.

- To encourage the maintenance of immunization record cards by mothers:

    1. The project should consider finding a mechanism to sell the cards-either initially or the replacement card if a mother loses hers. Because it is against government policy to sell the blue immunization cards, the project may have to adopt the pink growth monitoring cards, which also have immunization information on them, to do this. This has the added advantage of giving the mother access to the information regarding her child's nutritional status as well.

    2. The project should work with the MOH to consider a system where priority for all medical services is influenced by whether a mother has the immunization card.

    3. The project should discuss the problem with the mothers' clubs and the development committees.

- Mothers should be encouraged to take their children to the clinics or other MOH sites for immunizations rather than depending on the health promoter to bring them.

- The team should encourage health promoters to leave a small-sized poster of ORS mixing instructions when she gives a mother this education. This gives the mother something to refer to if she later has difficulty remembering the specifics, and it also extends the effort when house visitors also see it.

- The health project should also target grandmothers in its health promotion efforts since they have so much influence over the care of the children.

- The health project should add a message about never using baby bottles to its message about breast-feeding.

- The project needs to reassess whether understanding of the message about recognition of acute respiratory symptoms is being appropriately tested by the question used on the midterm survey.

- The project should train the development facilitators in the promotion of family planning with community men.

- The project should make every effort to reinstate the use of the mural boards or some other mechanism for health information feedback at the community level.

Relevance to Development

- The whole World Vision team should continue the efforts they are making to truly integrate the Child Survival work with the other development sectors.

- There should be more support and supervision across projects at the village level between health and development staff. Coordination in the scheduling of village visits would also increase efficiency.

Design and Implementation

- The information system for the project should be shared with the other WVDR community development projects-in design, implementation, maintenance, and cost. It is also recommended that a current member of the staff be appointed immediately to be responsible for the maintenance of the information system.

- The team is well trained in the need for and use of the information it is generating. However, it needs to get technical assistance to simplify the information system and to make it applicable and useful for other sectors.

- The project should emphasize the recognition and reporting of immunizable diseases, particularly measles, in its information system. This could happen either through the health promoters or through the establishment of mother sentinels.

- The rotating credit fund for income generation as an incentive for health promoters should be maintained and expanded as resources permit. The experience of the development team should be capitalized upon to provide assistance with the implementation and management of this part of the project.

- The project recognizes that the retention and motivation of health promoters is a significant problem. Other suggestions besides the small-scale credit program include:

    1. Give more specific selection criteria to the community during the selection process

    2. Look for health promoters who may be a little older and more stable and have a little more time for the work.

    3. Give priority to health promoters for any medical service.

    4. Reevaluate whether the project is asking too much time of its volunteers. Perhaps the project needs to prioritize their work more tightly.

- The project needs to look for any possible way to motivate and support the people in the MOH. This might include training, joint visits, and review of monthly reports for planning and evaluation. The area health supervisors should consider the health promoter supervisors at the clinics as their counterparts.

- The project needs to send the monthly reports of all its Child Survival activities to the clinic staff as well as the regional staff at the MOH. These include the health promoters' reports for the specific communities that fall under the responsibility of a given clinic as well as those of the supervisors.

- The health team needs to work more closely with MOH staff to actively use the health data (particularly the target population totals) in planning and evaluation of its immunization efforts.

- At the MOH request, the development team should consider expansion into some of the urban neighborhoods around the town of Barahona the next time it is planning to extend its efforts.

Sustainability

- All sectors should closely consider the matching contribution and efforts expected from the community for any project inputs in order not to increase dependence on outside resources and detract from the potential for sustainability.

- The project needs to plan more carefully for the phase down of efforts in the 15 Barahona villages as it begins to think about its expansion into Bahoruco.

- The project should make an effort to calculate some its real costs (such as the cost/child fully immunized or the cost/ORS packet distributed) as it considers its recurrent costs and potential for cost recovery.

- During the third year the project should restrain from a mode of geographic expansion. It should maintain its current low level of activity in Bahoruco, reserving it as an area of proposed expansion for the project's second phase. There are areas of project implementation that need to be strengthened in Barahona, and these should be the focus of the remaining funds in the budget.

APPENDIX 1

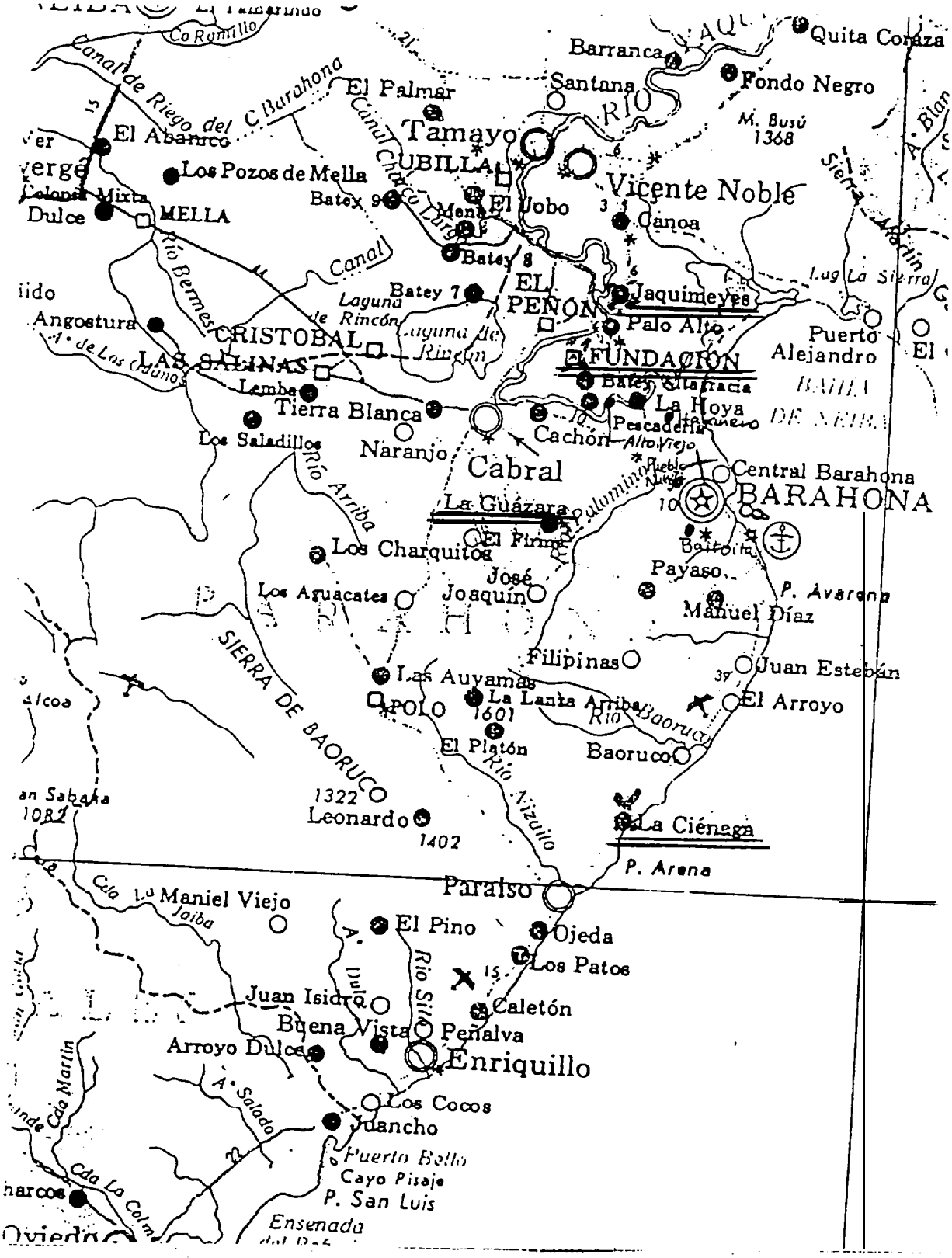
WORLD VISION DOMINICAN REPUBLIC
CHILD SURVIVAL MIDTERM EVALUATION SCHEDULE

September 15-25, 1993

September 15	Arrival of Marcie Rubardt
September 16	
8:30	Meeting with Dr. Melba Franky de Borrero Pan-American Health Organization
11:00	Meeting with Cesar Lopez World Vision Field Office Director
2:00	Meeting with Claudio Done Field Office Finance Director
9:00	Arrival of Dr. Milton Amayun from World Vision headquarters
September 16 and 17	Meetings with health management team to discuss the evaluation, develop a plan of action, assign responsibilities, review questionnaire, etc.
September 17	
4:00	Meeting with Dr. Felix Alcantara Health Director, PLAN International, Santo Domingo
September 18	
A.M.	Travel to Barahona
2:30	Meet with field health team: area health coordinator, two supervisors, and secretary
September 19	Visit two communities in Bahoruco and Escuela Campesina de Agricultura Sostenible (ECAS)
20 September	
8:30	Meet with Dr. Man010 Feliz and Dr. Victor Ventura from Regional Ministry of Public Health
9:30	Meet with 11 health promoters
2:30	Joint meeting with health team and development team

September 21	
9:oo	Visit rural clinic in Fundacion
lo:oo	Visit with development committee, health promoters, and mothers in Palo Alto
2:00	Visit with Health Promoters and mothers in community of Bahoruco
5:30	Meet with evaluation team to review results and recommendations
September 22	Continue meeting with remaining team members and health team staff to review results and recommendations
September 23	
A.M.	Return to Santo Domingo
3:30	Meet with Sara George, USAID
4:30	Meet with management staff from Santo Domingo to review results and recommendations
September 24	National Census Work on writing report
September 25	Departure

APPENDIX 2
MAP OF PROJECT AREA



APPENDIX 3
SURVEY TOOL

A. CAPACITACION PARA EL EQUIP0 DEL PSI (1)

TEMA	FECHA	HRS	FACILITADOR	PERSONAL CAPACITADO
SUPERVISION	02/92	18	URC	NERTHA
SIDA	02/92	21	PLUS	NERTHA
CED/TRO	02/92	32	URC	ANDREA/ANA
PA1	02/92	8	SESPAS	ANA/ANDREA NERTHA
MANEJO FINANZAS PSI	03/92	32	WVRD SANDRA	CARMEN NERTHA
EDUCACION POPULAR	03/92	8	VMG	ANA/ANDREA
SIDA	03/92	36	PLUS	NERTHA
SOSTENIBILIDAD	03/92	12	WVRD FE GARCIA	EQUIPO/ LIDERES
MURAL DE INFORMACION	03/92	4	WVRD FE GARCIA	EQUIPO/ LIDERES
SIDA	05/92	18	PLUS	NERTHA
COMUNICACION SOCIAL	06/92	12	URC	ANA
PREVENCIO DROGAS	06/92	8	HOGAR CREA	ANDREA/ NERTHA/ IVELISSE
SOSTENIBILIDAD	07/92	24	JIM RICE	EQUIPO
LACTANCIA MATERNA	08/92	48	URC	NERTHA
COMUNICACION SOCIAL	08/92	12	URC	NERTHA
DONDE NO HAY DOCTOR	08/92	40	CUERPO DE PAZ	ANDREA/ ANA UNA PROMOTO

A. CAPACITACION PARA EL EQUIP0 DEL PSI (2)

TEMA	FECHA	HRS	FACILITADOR	PERSONAL CAPACITADO
ESPACIAMENTO EL EMBARAZO	10/92	48	URC	NERTHA
ESPACIAMENTO EL EMBARAZO	10/92	32	URC	ANDREA/ANA
SIDA	11/92	16	PLUS	NERTHA
LACTANCIA MATERNA	11/92	36	URC	ANA/ANDREA
TRABAJO COMUNITARIO	12/92	40	VM	CARMEN/ANA/ NERTHA
DERECHOS DEL NINO	12/92	6	CEDOIS	ANDREA/ANA
SIDA	12/92	16	PLUS	NERTHA
SISTEMA INFORMACION	02/93	8	VM	EQUIPO
ALLENTO DEL FUTURO	03/93	40	PROYECTO ESPERANCA (BOLIVIA)	CARMEN/ NERTHA
SIDA	04/93	16	PLUS	NERTHA
ACTIVAD GENERADORA INGRESO	05/93	16	VMCR D. BIFUS	EQUIPO
ENCUESTA PROCESAMIENT DATOS	08/93	16	WVRD T. VENTIMIGLIA	EQUIPO

Número total de capacitaciones para el equipo del PSI:28
Número total de horas de capacitacion para el equipo del PSI: 623.

C. CAPACITACION COMUNITARIA (1)

TEMA	FECHA	HRS	CLASE	FACILI-TODOR	GRUPO
SANEAMENTO AMBIENTAL AREA 1 AREA 2	17/01/92	3	CAP	PROTOR PSI	MADRES
INDRODUCION AL PSI AREA 1 PUEBLO NUEVO LA GUAZARA	06/92	2	CAP	PSI	COMITE
PLANTAS MEDINALES PUEBLO NUEVO	06/92	3	CAP	PSI	CLUB MADRES
ECONOMIA DEL HOGAR HAITO VIEJO	06/92	3	CAP	PSI	CLUB MADRES
INTERVENCIONES DEL PSI EN AREA 1	21/08/92	2	CAP	PSI	LIDERES
INTERVENCIONES DEL PSI EN AREA 2	25/08/92	2	CAP	PSI	LIDERES
PROBLEMAS COMUNITARIOS 15 COMUNIDAD	08/92	30	CAP	PSI	MUJERES
IMPORTANCIA EL PAI AREA 1	09/92	2	CAP	PSI	LIDERES MADRES PROMOTO PROFESO
LOGROS DEL 1 ANO PSI LA HOYA	08/11/92	3	RET	PSI	MADRES PROFESO LIDERES COMITE

C. CAPACITACION COMUNITARIA (2)

TEMA	FECHA	HRS	CLASE	FACILI-TADOR	GRUPO
APOYO AL PAI AREA 2	19/11/92	3	COORD	PSI	COMITE
ESPACIAMENTO DEL EMBARAZO BAHORUCO	26/10/92	3	CAP	PSI	PAREJAS
ESPACIAMENTO DEL EMBARAZO LA HOYA	26/11/92	2	CAP	PSI PROMOTO	PAREJAS
LOGROS 1 ANO AREA 2	14/12/92	4	RET	PSI	COMITE
PAI FUDECO	03/12/92	3	CAP	PSI	MADRES
PAI PUEBLO NUEVO	07/12/92	2	CAP	PSI	MADRES
APOYO AL PAI BAHORUCO	10/02/93	2	COORD	PSI	MADRES LIDERES PROMOTO
PAI AREA 2	10/02/93	2	CAP	PSI	LIDERES MADRES PROMOTO PROFESO
INTERVENCION PSI JUAN ESTEBAN	17/02/93	4	CAP	PROMO PSI	MADRES COMITE
PAI EL ARROYO	02/93	4	CAP	PSI	LIDERES
PAI Y IRA JUAN ESTEBAN	03/93	6	CAP	PSI	MADRES

C. CAPACITACION COMUNITARIA (3)

TEMA	FECHA	HRS	CLASE	FACILI-TADOR	GRUPO
IRA CACHON	08/03/93	2	CAP	PSI	CLUB MADRES
TRO CIENAGA FUDECO	12/05/93	2	CAP	PROMO PSI	MADRES
NUTRITION JUAN EST CIENAGA	28/04/93	3	CAP	PSI COMITE	MADRES
IRA/TRO PESCADERIA	11/05/93	2	CAP	PSI	MADRES
TRO FUDECO	12/05/93	2	CAP	PSI	MADRES
TRO FUNDACION	05/93	2	CAP	PSI	MADRES
IRA GUAZARA	27/05/93	3	CAP	PSI	CLUB MADRES
LACTANCIA MATERNA NUTRICION AREA 2	18/05/93	3	CAP	PSI	MADRES
LACTANCIA MATERNA INMUNIZ AREA 1	18/06/93	4	CAP	PSI	MADRES
COORDINACION PSI JAQUIMEYE	06/93	2	CAP	PSI	COMITE PROMOT PSI SSID
NUTRICION AREA 1	06/93	6	CAP	PSI	MADRES COMITE
PAI 15 COMUNIDA	06/93	15	CAP (15)	PSI	MADRES PADRES

C. CAPACITACION COMUNITARIA (4)

TEMA	FECHA	HRS	CLASE	FACILI-TADOR	GRUPO
SALUD DE LA MUJER (PAP) JUAN ESTEVAN	06/93	2	CAP	PSI SESPAS	MUJERES
INPORTANCIA DEL PSI AREA 1	20/07/93	2	CAP	PSI	COMITE
IMPORTANCIA DEL PAI AREA 1	25/02/93	2	CAP	PSI	LIDRES CLUB DE MADRES PROMOTO PROFESO

Número total de capacitaciones comunitarios: 35
Número total de horas de capacitaciones comunitarias: 135

URC — University Research Corporation
PLUS — Patronato pro la Lucha Contra la Sida
SESPAS - Ministry of Health Department of Public Health
VMG — Vision Mundial de Guatemala
WVRD — World Vision Relief and Development
Hogar Crea — Drug treatment program
CEDOIS - Centro Dominicano de Organizaciones de Interes Social
PSI — Proyecto de Supervivencia Infantil

CAP - Capacitacion: initial training
RET - Retroalimentacion: review

APPENDIX4

SUMMARY OF TRAINING RECEIVED BY STAFF

ENTREVISTA CON LOS PROMETEROS DE SALUD

Propuesto:

1. **Verificar** que sepan lo necesario de las actividades de la sobrevivencia infantil **(vacunas,** diarrea, ARI).
2 **Averiguar** su **motivación** por **el** trabajo y si se sienten bien apellidos.
3: **Verificar utilización** de **los** cuademos de **información.**

Método: Unas preguntas especificas con **descocían** en general.
Revisión de la sistema de **información** a **su** nivel

Preguntas Especificas:

1. Que consejo dan Uds. a las **mamás** quienes encuentran a **los niños** con la diarrea?
2. Que es el consejo que les parece lo **mas** importante?
3. Cuantos **contactos** son necesarios **para** completamente vacunar a **los niños?**
4. Que hacen Uds. **para** asegurar que este vacunado un niiio **coya** mama no lo trae a **las** sesiones?
5. Cuando un **niño** esta resfriado, que son **los** simtomas que **indican** que debe ir a la **clínico?** Si no tiene **esos** simtomas, que consejo le dan a la mama?
6. Que son **las cosas** lo mas dificiles que encuentran en este trabajo de salud?
7. Como ayuda el trabajo que hacen con **los** verdaderos problemas de **su** pueblo? Que es el **problema** mayor de su pueblo?
8. Porque les **interesa** este trabajo? Que parte mas les **gusta?** Les es **problema** que no **reciben compensación** monetaria?
9. Cuando **últimamente** les **visito** su supervisor(a)? Quien es? De que hablaron?
10. Que materiales utilizan **para** ayudarles **enseñar** a la gente?
11. Cuanto tiempo al mes necesitan **para** mantener el sistema de **información?** Que hacen con la **información** que consiguen?
12. Que hacen cuando un **niño** no esta ganando peso?
13. Cuanto tiempo a la semana necesitan **para** mantener el sistema de **información?**
14. Cuanto tiempo trabajan a la semana?
15. Cuantas **visitas** de domicilio hacen por semana?
16. **Las** coorcinatoras sienten que a **veces** es **difícil** mantener la **motivación** de las **prometerás para** el trabajo. Que piensan?

ENTREVISTA CON LOS EMPLEADOS POR EL PROYECTO
(supervisoras de salud)

Pmpuesto:

1. Verificar que sepan lo necesario de las actividades de la sobrevivencia infantil (vacunas, diarrea, ARI) para bien enseñar a los prometeros.

2. Conseguir sus ideas sobre el proyecto:

   - Ideas y opiniones sobre los problemas y beneficios del proyccto.
   - Ideas sobre como el proyecto puede ser sostenido.
   - Nivel y calidad de colaboración con el Ministerio.
   - La gerencia del proyecto: apollo material, supervisión, y formación que reciben

3. Funcionamiento del sistema de información.

Preguntas Especificas:

1. Expliquen como utilizan el tiempo durante una semana normal?
2. Cuanto tiempo a la semana pasan trabajando con el sisterna de información? Como afecta su trabajo la información que ganan?
3. Según su experiencia que son los razones que los niños tomaban desnutridos? Que se puede hacer para resoudre el problema?
4. Cuando visitan a las mujeres quienes vienen de dar a luz, de que debe hablar la prometerá?
5. Que es el mensaje mas importante de cada intervención que tratan enseiiar a la gente? Que materiales utilizan para ensefiar?
6. Que son los cumplidos de que se sienten lo mas contentas?
7. Que son las cosas mas dificiles que encuentran haciendo su trabajo?
8. Que piensan de la motivación que encuentran en los pueblos? Que son unas de las acciones significativas de la parte de las comunidades adelantando el trabajo de salud?
9. Como se integra el trabajo del proyecto con el del Ministerio? Que es el papel de cada uno?
10. Que formación recibieron para prepararles por este trabajo?
11. Hay otra formación que necesitan para mejor hacer su trabajo?
12. Tienen el apollo nccesario para bien hacer su trabajo? Social? Material? Supervisión?

ENTREVISTA CON LA DIRECTORA

Propuesto:

1. Revisión del Survey.
2. Revisión de las estadísticas: inputs, outputs, beneficiaries, targeting.
3. Revisión del porsupuesto (?budget?).
4. Revisión del sistema de información.
5. Como es diferente el proyecto de lo que propusieron e el DIP?
6. Colaboración con otras agencias.
7. Colaboración con el Ministerio (counterparts?).

ENTREVISTA CON EL MINISTERIO

Propuesto:

1. Posibilidades para sostener el proyecto.
2. Si el proyecto complementa bien el plan del Ministerio para el desarrollo del sector de la salud.
3. Si la gente del Ministerio están contentas con el trabajo del proyecto.
4. Si reciben información del sistema de información.
5. Aéreas de colaboración.
6. Hablar de como se puede ampollar a un modelo de voluntarios al nivel de la comunidad
7. Que se puede hacer con la formación de medicos para cambiar el costumbre de tratar al diarrea siempre con medicamentos?

ENTREVISTAS/DISCUSIONES CON la GENTE DE COMUNIDAD

Propuesto:

1. Verificar la comprehension de los mensajes y de los materiales de salud.
2. Investigar la motivación y nivel de participación de los campesinos para ampollar el proyecto (sustainability).
3. Verificar la utilización del sistema de información al nivel del pueblo.
4. Saber si los campesinos piensan que el trabajo del proyecto releva bien a lo que necesitan (pensando también en el desarrollo en general y no solamente en cuanto a la salud).
5. Discutir como se puede pagar para los servicios del proyecto cuando se acaba el dinero.

Método:

Descocían de grupo con los alcaldes, equipo de salud, mujeres, mamas, o otras.

Preguntas Especificas:

1. Quien dirige el trabajo de salud en la comunidad?
2. Como saben de las actividades del proyccto aqui?
3. Como fue la capacitación sobre la salud? Que fue el contenido? Como les pareció? Que todavía falta?
4. Que es el trabajo que hace el comete?
5. Que información tienen sobre la salud en la comunidad?
6. Como ampolla el comete al trabajo de salud? A las prometerás?

VISITAS DE DOMICILIO

- Pedir las tarjeta de vacunacibn.
- Preguntar sobre que hace cuando su niño tiene la diarrea.
- Preguntar sobre la alimentación y lactación del niño.
- Preguntar sobre su utilización de algún método de planificación familia.
- Observaciones de vivienda.

DISCUCION CON TODO EL EQUIP0 DE CAMP0 DE VM

Propuesta:

1. Idea general sobre como va la integración entre el trabajo de salud y el de desarrollo.
2. Hablar de las necesidades mas amplias que las salud que se encuentran en las comunidades.
3. Discutir que quiere decir desarrollo en el contexto de este trabajo.

Preguntas Especificas:

1. Para el verdadero desarrollo, a veces se necesitan varias intervenciones complementarais. Que son otras actividades posibles que podría hacer Visión Mundial que pueden complementar las actividades de salud que ya hacen?

2. Piensan que las actividades del proyecto responden a las necesidades verdaderas de la gente? Hay otras problemas de salud mas serosas a que el proyccto no se dirige.

3. Que son las posibilidades por la recuperación de dinero de los puebles mismos? Como se podría implementar esta?

4. Que son las fuerzas/actividades/maneras que mas les ayudan de la parte de su supervisor(a)?

5. Empowerment???

6. Que es el impacto que ven del proyecto? Como ha mejorado la vida de la gente?

1993 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A
W.V.R.D./DOMINICAN REPUBLIC CHILD SURVIVAL PROJECT
#PDC-0500-G-00-1065-00

FIELD	Actual Expenditures To Date (10/1/91 to 9/30/93)			Projected Expenditures Against Remaining Obligated Funds (10/01/93 to 9/30/94)			DIP Budget (Columns 1 & 2) (10/01/91 to 9/30/94)		
COST ELEMENTS	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
I. PROCUREMENT									
A. Supplies	1,630	0	1,630	7,575	22,000	29,575	9,205	22,000	31,205
B. Equipment	3,699	46,577	52,276	(2,634)	7,073	4,439	3,065	53,650	56,715
C. Services/Consultants	1,045	0	1,045	12,549	0	12,549	13,594	0	13,594
SUB-TOTAL I	8,374	46,577	54,951	17,490	29,073	46,563	25,864	75,650	101,514
II. EVALUATION/SUB-TOTAL II	11,172	0	11,172	12,704	0	12,704	23,876	0	23,876
III. INDIRECT COSTS									
Overhead on Field (%)	17,038	55,650	72,688	16,291	83,398	99,560	33,200	139,048	172,248
SUB-TOTAL III	17,038	55,650	72,688	16,291	83,398	99,560	33,200	139,048	172,248
IV. OTHER PROGRAM COSTS									
A. Personnel	49,728	0	49,728	27,845	0	27,845	77,573	0	77,573
B. Travel/Per diem	5,438	0	5,438	8,092	0	8,092	13,530	0	13,530
C. Other Direct Costs	16,181	3,125	19,306	12,041	(3,125)	8,916	28,222	0	28,222
SUB-TOTAL IV	71,347	3,125	74,472	47,978	(3,125)	44,853	119,325	0	119,325
TOTAL FIELD	107,931	105,352	213,283	94,387	109,346	203,680	202,265	214,698	416,963